CHILDREN AND YOUTH WITH SEVERE EMOTIONAL DISTURBANCE– THE PROBLEM FOR TEXAS

Report of the Task Force on
Children and Adolescents with
Severe Emotional Disturbance

Hogg Foundation
for Mental Health

The University of Texas
Austin, Texas 78713-7998

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CONTENTS

5 Introduction

7 Status, Concerns, and a Call for Action

13 Strategies for Effective Services
14 Prerequisite Actions
17 Programs and Services
25 Organization and Support

30 The Next Steps

33 Appendix A - List of "Key Stakeholders" Meeting Participants
34 Appendix B - Target Population Definition for Children with SED
35 Appendix C - Resources

39 Endnotes

Since the early presidency of Thomas Jefferson, this nation has been committed–as no nation on earth–to the education of our children. We have valued the minds of our young as America's richest resource and we have honored that value by dedicating much of our wealth to the development of those minds.

– Lyndon B. Johnson
"September Song" speech (1977)

Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available.

– U.S. Congress, Office of Technology Assessment
Children's Mental Health: Problems and Services – A Background Paper
(1986)

INTRODUCTION

In 1987, to mark its 50th anniversary and to plan for the decades ahead, the Hogg Foundation for Mental Health appointed three commissions to study how mental health services could be improved for all Texans in need. Each commission was created to focus on a broad population: persons with severe mental illness, children and their families, and adolescents and young adults.

Within these categories, the commissions selected specific populations on which to concentrate their efforts and recommendations. The Commission on Community Care of the Mentally Ill studied the mental health delivery system for Texans over age 18. Its report, *Texans with Severe Mental Illness*, includes findings and recommendations for providing more adequate and effective community services to adults with severe mental illness and their families. The Commission on the Mental Health of Children and Their Families selected young children from birth to six as its area of study, with an emphasis on positive growth and the prevention of later social and emotional problems. *Texas Children* is a report of this group's findings and recommendations. The Commission on the Mental Health of Adolescents and Young Adults focused on the major forces that influence and shape the lives of young people from the preteen years to the 20s. Its report, *Reaching Out to Youth*, offers strategies to provide greater support and understanding to these young people.

Each commission recognized the pressing needs of children and youth with severe emotional disturbance (SED), yet none felt that it had the time to devote to this special population. From this recognition, the Task Force on Children and Adolescents with Severe Emotional Disturbance was developed.

The task force was composed of psychiatrists, psychologists, educators, and other mental health professionals from throughout Texas and included representatives from each of the three commissions. To aid in their study of resources and systems, task force members invited key stakeholders–representatives of agencies and advocacy groups with an active interest in planning or providing services to the target population–to describe each respective organization's roles and to identify gaps in service delivery and areas in need of change. The study also was enhanced by information and recommendations generated by a policy research project funded by the Hogg Foundation at the Lyndon B. Johnson School of Public Affairs of The University of Texas at Austin entitled "Financing Care for Seriously Emotionally Disturbed Children and Youth in Texas."

The task force quickly recognized the dearth of services as well as barriers to providing services, and it identified several programs that are too new to evaluate yet bear watching as potential models for replication throughout the state. These findings and others are reported on the following pages.

Robert S. McKelvey, M. D.

Robert S. McKelvey, M. D.
Chairman,
Task Force on Children and Adolescents
with Severe Emotional Disturbance

STATUS, CONCERNS, AND A CALL FOR ACTION

Abused children. . . children in poverty . . .pregnant adolescents. . . adolescents on drugs. These and other youth who are troubled and in trouble have captured the attention and the concern of the nation. One problem of youth, however, that has failed to arouse sympathy or support despite its prevalence is severe or serious emotional disturbance (SED)

Preschoolers and school-aged youth with emotional disturbance generally exhibit signs that indicate their illness. They may be consistently unreachable or inattentive, stare vacantly, seem unhappy, be unable to sit still, act inappropriately, or fail to get along with other children. They may have violent outbursts; they may be openly psychotic.

Look at the national statistics:

- By the most conservative estimate, 12 percent of children under age 18–more than 7.5 million young Americans–suffer from a mental disorder.[1]
- An estimated 40 percent of these youngsters–some 3 million–will have severe emotional disturbance.
- Approximately 2.5 million children in this country received treatment in 1985 for a mental disorder. This means that at least another 5 million children needed some type of intervention but did not receive any treatment.[2]
- The National Mental Health Association estimates that over $1 billion is spent by states just on the care of children in state hospitals and out-of-state facilities.[3]

Look at the statistics for Texas:

- Based on the national statistics, some 600,000 Texas children and youth may be emotionally disturbed, some 251,000 of them severely so.
- Of the 251,000 youngsters with SED, approximately 151,000 in 1988 received help from the private sector, leaving 100,000 in need of public mental health services.
- Texas Department of MHMR provided help for about 22,000 or little more than one out of five of those young people in need.[4]
- Despite these conservative estimates, the identification rate of emotional disturbance for school-age children in Texas by public schools is 1.1 percent,[5] a rate that is undoubtedly lower than the true prevalence.
- It is estimated that Texas spent over $1.4 million on 27 out-of-state placements in 1988 and treated almost 1,600 children in state hospitals in 1987,[6] but still ranked 49th (out of 51 states) in spending per capita for mental health services for both children and adults.[7]

BARRIERS TO EFFECTIVE SERVICES

The lack of services for children and adolescents with severe mental illness is compounded by a variety of problems. The first is definition. No single, uniform definition spells out the criteria for inclusion in the category of youth with SED. Agencies and service providers use different terms to define the population and different measurements to determine severity, duration, and need. This leads to delays and inconsistencies in identifying children in need, determining eligibility, and initiating appropriate treatment. In fact, it is due to inconsistencies in definition that the statistics on number of SED youth are not facts but approximations. Although they are inexact, they are the only figures available on which decision makers and planners can determine service needs.

Large proportions of disturbed and disruptive children do not receive adequate, comprehensive services. Available services are unnecessarily restrictive, and poor children are particularly at risk.

- June M. Tuma, Ph.D.
"Mental Health Services for Children: The State of the Art" (1989)

A second barrier is the lack of comprehensive planning and coordination. Children and youth with SED tend to have more than one problem, leading to a need for services from more than one agency or organization and for different types of care at different times. Without an overall plan that takes these needs into account and that facilitates collaboration among service-providing agencies, serious gaps in services will continue to exist and costs will continue to increase.

Local community services are in short supply for children and adolescents, both for outpatient and residential care. Research reveals that some children can function in community-based care all or most of the time,[8] some need out-of-home placement, at least during periods of crisis. Traditionally, options for care were either a hospital or the child's home. Increasingly, however, hospitalization is coming to be viewed as a last resort, appropriate only when less restrictive environments prove unsuccessful. Despite this change in philosophy, little effort has been expended to provide options such as partial hospitalization, day treatment programs, or other community-based alternatives to out-of-home placement, and youngsters in need of hospitalization continue to be placed far from home. Services that provide a continuum of community care for Texas youth with SED rarely are available.

The stigma of mental illness forms another barrier to service provision. Parents often are averse to accepting a diagnosis of severe emotional disturbance, and they tend to be reluctant to communicate the nature of a child's illness to others. Services may exist but go unheeded, for families do not seek help for illnesses they do not recognize. A wide gap exists between the intellectual understanding of mental illness and the emotional recognition and acceptance of this fact on a personal or family level.

The sheer size and cultural diversity of Texas complicate service provision. The state has a youthful population, with almost 24 percent under age 15 and 18 percent ages 15 to 24, together accounting for 42 percent of the population in the 1980s. Although the proportion of young people is projected to decline in the coming years, the actual number is expected to increase from seven million in 1985 to almost ten million by 2035.[9] The number of children with SED is projected to increase at the same rate.

The state also has an increasingly heterogeneous population. Hispanics are the youngest and most rapidly growing population. Among Texas children from birth to 15, Hispanics form about 30 percent of the population, a figure projected to increase to 45 percent by 2035. Long before then, Anglo youth will cease to comprise a majority in Texas; by 2015, Anglos and Hispanics under age 15 are expected to be equal in number.[10] The cultural background and beliefs of the burgeoning Hispanic population, along with those of the relatively stable Black population, the growing Asian population, and other ethnic and cultural minorities, must be recognized by planners and providers and incorporated into social and mental health services.

Lack of adequate funding is probably the greatest barrier to developing needed mental health services for youth under age 18. The low priority placed on mental health funding in general, and the lack of funds for agencies that provide services to children and adolescents with severe emotional disturbance in particular, decrease the ability of these agencies to offer high quality services. A recent analysis of services for SED children in Texas concluded that although key programs such as case management, therapeutic foster care, respite beds, day treatment, and home-based services are provided in some areas, inadequate funding prevents them from being offered to a majority of the youth who need them. As a result of low funding, services for children in SED are either nonexistent, inadequate, or inappropriate.[11]

Public and private funding that is available is directed primarily toward intervention programs for youth in crisis situations such as suicide attempts or violent acts, detracting from the development of services to ameliorate or prevent mental illness. Although all types of mental illness cannot be prevented, children at risk can be identified and families can be helped to provide more positive and constructive environments to

encourage healthy mental and physical development. Increasingly, the schools are being recognized as the locus for identifying youngsters with SED as well as for mental health services. The long-range impact would be a smaller percentage of troubled and disturbed youth.

Problems in obtaining care for youngsters with severe problems begin early. In a recent survey of integrated or mainstream child care services in Texas, parents indicated a need for greater sensitivity and awareness within the child care industry for the needs of children and their parents. The study revealed that registered family homes, which provide a major percentage of infant and preschool care, are more likely to serve children with visual, hearing, and speech impairments than those with severe emotional problems or severe developmental delays.[12]

Finally, no clear guidelines exist for working with youngsters aged 10 to 14, a prime age range for recognition of danger signs and prevention of future problems. No longer considered little children yet not ready for the privileges or problems of high school, this age group is underserved in every aspect, not just those dealing with mental health. Programs tend to focus on prevention for infants and young children and intervention to help older teenagers in trouble, but little is available for young adolescents unless they break a law or experience a crisis. Belief is widespread that these youngsters will outgrow their problems. Too often, they do not. Far more effort is needed to prevent severe emotional disturbance in young people as well as to improve the outlook for youth with SED.

Because schools are in such a crucial position to first recognize disturbed children, agencies would like attention paid to this issue. They would also like to see more interagency collaboration on day treatment and after-school programs.

- Mental Health Association in Texas
Do Kids Count? (1989)

CONCERNS FROM THE FIELD

To obtain a broad perspective, the task force invited representatives of agencies and advocacy groups that serve children and youth with SED to express their concerns about service provision and to suggest ideas for implementing more effective services. Following is a summary of the concerns identified by these representatives and by others who work with or for the target population. (For a list of participants, see Appendix A.)

1. Underidentification. Texas is now identifying less than 1 percent of its children as SED, and in one-third of the counties, no children are being identified.
2. Unnecessary or inappropriate recommendations for hospitalization. In many cases, the family is not considered in the placement of children and youth.
3. Lack of community resources. In rural areas, all services are in short supply.
4. Shortage of psychiatrists, psychologists, and other professionals trained to work with children and youth.
5. Ineffectiveness of Memoranda of Understanding (MOU). Initially developed to encourage coordination between agencies, MOUs have become too voluminous to track and are difficult for staff to understand. They define narrow populations for service and are fragmented due to lack of overall planning.
6. Lack of services for youth with dual diagnoses such as mental disturbance and substance abuse.
7. Impact of insurance on services. Private hospitals tend to "dump" children into the community when insurance money runs out.
8. Lack of established priorities for providing children's services, resulting, for example, in failure to use Medicaid effectively for the treatment and care of children with mental illness.
9. Need for greater cooperation and coordination between the public and private sectors as well as among state agencies.
10. Need for more culturally appropriate services; minority youth are severely underserved.
11. Need for changes in policy and funding to enable the poor to obtain essential mental health services.

A CALL FOR ACTION

Texas can do more for its children at risk of mental illness. Many of the factors that place children at risk for developing mental and behavioral disorders are known. For some, the risks appear early: low birthweight, premature birth, and genetic predisposition. Other risk factors often follow, singly or together, and include poverty, family distress or dysfunction, physical abuse, neglect, and family substance abuse.

Too many young Texans are at risk. One in four is growing up in poverty.[13] A large number are growing up in single-parent families, and an increasing number are contending with violent and/or dysfunctional families and experiencing physical and sexual abuse. A disproportionate number of infants born to poor and teenage women have a low birthweight. Effective intervention to assist these young children and their families is needed urgently.

Texas also can do more for its youth with SED. A child with mental illness impacts an entire family, draining resources and support from every member and negatively affecting family relationships. Parents of these children and adolescents recognize areas that demand attention. In a national survey, parents of children with SED identified financial assistance, support groups for parents and siblings, and respite care as essential services that are particularly difficult to obtain. They also expressed a need for more information about the causes of emotional disorders, how to treat their children's problems, and how to cope not only with the child with SED but also with the individual and family problems created by the illness.[14]

Some new initiatives have been developed to help Texas children and adolescents with severe emotional disturbance and their families. Many more are needed.

Parents and professionals alike must realize, however, that even if all children with severe mental illness were identified and treated, the problem would not go away. Many youngsters with SED have a chronic problem. No magic waving of a wand, no prescription for medication, and no intensive therapy is going to alter these conditions to the extent that these youths will be "cured." Lives can be improved, however, and people can learn to handle their situations. For this to happen, it is necessary to involve families, teachers, and community resources to help these young people as well as their families cope more effectively with their problems. Further, it is necessary to understand limitations as well as to view brighter horizons.

Following are the findings of the task force on problems and issues, new and ongoing program efforts, and strategies for more effective services.

STRATEGIES FOR EFFECTIVE SERVICES

Providing services for children and youth with severe emotional disturbance is complex . Until recent years advocacy, funding, and programs for persons with mental illness were directed primarily toward adults; youth with SED received scant attention and minimal funds. Texas ranks a dismal 48th out of the 50 states in per capita spending on public mental health services. In 1988 the state spent less than 14 percent of its total community and residential budget on services to children and youth[15] despite the fact that children under age 15 accounted for 24 percent of the Texas population, youth from 18 to 14, another 18 percent. In the past, funds have not been earmarked for children and youth but have been drawn from appropriations for the entire population of Texans with mental illness. The need for greater attention and specific funding for this young population can be ignored no longer.

But funds alone will not resolve this issue. Because of lack of attention in the past, there is no database on young Texans with mental illness. There are no accurate figures on who these youngsters are, where they are, or how many there are. There is no single definition of SED youth to enable these figures to be obtained. Until basic actions are taken to define and identify the population, it is difficult for policymakers and administrators to plan effective action.

Clinically, the most appropriate mode of treatment for children with mental and emotional problems is often a community-based service that is centered on the needs of the child and focused on the family unit. However, policymakers and third party payers have supported the development of few of these kinds of services.

- National Mental Health Association
Final Report and Recommendations of the Invisible Children Project (1989)

Whatever the problems of policymakers might be, youth with SED cannot wait. Their needs and the needs of their families are immediate. Programs are essential to provide community resources to serve this population now; a greater number, reaching every part of the state, will be needed once additional numbers of children and adolescents have been identified. If youth are labeled with SED, it is incumbent upon the state to provide them with essential services.

There is a "catch-22" in that needed new initiatives are being implemented for this population, but many are in the initial stages. Thus, it is too early to determine what types of care and treatment are most effective and most appropriate for different age groups and

different types and degrees of illness. Research and evaluation are essential for developing, refining, and adapting programs to meet the many and varied needs of youth with SED.

What follows is a problem statement that places the many needs and suggested strategies in priority. At the same time, however, the task force recognizes that many actions must take place simultaneously and quickly. Children and youth with SED and their families should have a range of appropriate services available to them.

PREREQUISITE ACTIONS

Definition

A prerequisite for providing more extensive and effective services for children and youth with severe emotional disturbance is to establish a common, agreed-upon definition across agencies that provide services to this target population.

Policymakers, administrators, and service providers alike express concern about the fact that no common definition exists for children and youth with SED. Because of this, children are underidentified or identified inappropriately. As a result, many youngsters fall through the cracks, unable to obtain needed care and treatment.

The first step toward a common definition has been made by the Interagency Children's Mental Health Initiative, a coordinated project with representatives of nine state agencies that serve the target population and facilitated by the Mental Health Association in Texas (MHAT). The Initiative developed a definition, which is based on the model established by the Children's Demonstration Project of Ventura County, California, as a prerequisite to planning a continuum of care for children and adolescents with SED. This definition requires several independant criteria to be met in the areas of diagnosis, risk of separation from family, funcitonal impairment/symptoms, history, and special education assessment. First, the child must have a DSM-[1] R psychiatric diagnosis. Second, the child must be at risk of being separated from, or already be separated from, the family. Third, the child must have impaired functioning or severe psychiatric symptoms (psychosis, violence, suicidality) or be at imminent risk of decompensation or separation from the family. A separate category is reserved for special education students, identified as seriously emotionally disturbed, who also qualify under the definition. (See Appendix B for the full definition.)

With the preliminary acceptance of the participating agencies and the active support of the MHAT, the definition is likely to be approved and used by other agencies throughout the state that serve children and youth

with SED. The possibility for its widespread use is enhanced by increased awareness of the problem and commitment to solving it.

Identification

The Texas Education Agency (TEA) and the Texas Department of Mental Health/Mental Retardation (TDMHMR) have deplored the fact that children with emotional disturbances in Texas are not being identified and, in turn, not being served. Statistics bear this out. The TEA/TDMHMR Joint Task Force on Emotional Disturbance found that in one-third of Texas school districts in 1986, no students were identified as emotionally disturbed and in another one-third of the districts, less than one-half of one percent were so identified[16]. This underidentification exists despite studies that suggest that a high percentage of children and adolescents with SED are first recognized in the schools.[17]

If, as statistics indicate, some 12 percent of all children under age 18 have a diagnosable mental illness, the schools are not recognizing all who should be so assessed and helped. To remedy this, the TEA/TDMHMR Joint Task force has set this goal for 1990–that any school district with more than 200 students which does not identify at least 1 percent of its total population as emotionally disturbed must show evidence that it has "investigated through professionally adequate assessment a number of potentially emotionally disturbed students equal to 1 percent. In addition, such a district should be able to show that it is identifying and serving at least some children as emotionally disturbed." By 1995, the Task Force has recommended that at least 2 percent of students be assessed for possible emotional disturbance.[18]

State agencies often do not know the exact number of children they place in out-of-state and in-state psychiatric facilities, the amount of money being spent on their treatment, their diagnoses or even their whereabouts.

- Ann S. Ince
"NMHA Invisible Children" (1990)

These goals indicate concern for the target population and, if reached, would provide useful statistics as well as pave the way for obtaining help for youth in need. The Task Force recognizes that : (1) inappropriate labeling can be detrimental to children, branding them throughout their school years and therefore appropriately trained assessment personnel be available for all school districts and (2) identification without appropriate intervention serves no positive

purpose.[19] If children are identified with SED, prompt remediation should be available and accessible to them and their families.

One reason for the extremely low levels of identification is that school districts are responsible for paying about one-third of the costs of special education. This in effect eliminates any incentive to identify children with SED; it does not indicate lack of ability to identify these children. Another counter incentive is the lack of available services. School personnel see little purpose in identifying children for whom no treatment is accessible or help available.

Various validated instruments are available for identifying children with SED. More than 30 instruments and miscellaneous measures are cited in a 1988 Mental Health Service System Report.[20] With brief training, teachers, counselors, volunteers, and other interviewers can use an appropriate instrument to identify a majority of children with SED. All screening or initial assessments that indicate possible SED should be followed by more thorough evaluations.

In addition to existing assessment tools, the TEA has developed a behavioral checklist, with parallel forms to be completed by teachers and parents, that is keyed to the qualifying characteristics of children with SED as specified by PL 94-142. TEA also plans to have a consultant available at each of the agency's 20 Education Service Centers to answer questions regarding the educational programming for children with SED.

Public Education and Awareness

Until about 20 years ago, persons with mental illness for the most part were institutionalized, that is, they lived and were treated in hospitals or other residential settings away from public view. With the deinstitutionalization movement in the 1970s, the public became more aware of mental illness. Adults with chronic mental illness became visible; citizens' advocacy groups took up their cause and, backed by lawsuits in their favor, encouraged the development of community resources as an alternative to residential care.

With the implementation of CASSP and with the support throughout the state for family and community-based mental health care, Texas does not need to wait for a court order to make a valuable and long-term commitment to children. Our children deserve it.

- Mental Health Association in Texas
Do Kids Count? (1989)

Despite national attention to adults with mental illness, as well as to children with a variety of other problems that call for help, little attention has been paid to children and adolescents with serious mental illness. Sometimes referred to as invisible children, they remain a largely unknown population. Public education through the mass media and teacher education through in-service training would help increase the awareness, acceptance, and understanding of these troubled youngsters.

PROGRAMS AND SERVICES

Community-based Services

In 1976, the Task Force on Mental Health Services for Children and Adolescents in Texas reported a major need for community-based services. In 1984, a similar task force noted that "the same needs, multiplied by eight years of population growth and inattention to mental health services for youth, are continuing to be unmet today."[21]

The need for community services continues to increase. A report from the U.S. House of Representatives Select Committee on Children, Youth and Families projected a large increase in out-of-home placements in the next ten years, in large part because of child abuse, homelessness, and new conditions arising from crack cocaine and alcohol abuse. Nationally, between 1983 and 1986 the number of children who were inpatients in hospitals or residential care increased 60 percent, from 34,068 to 54,716. As the report points out, family-based services can prevent the unnecessary removal of children from their parents, but such community programs are too few and far between.[22] They can also prevent future problems. Recent research on homeless adults, for example, "shows a higher frequency of a history of institutional separation during childhood."[23]

To receive help, Texas children must deteriorate to the point of being at serious risk of harm to themselves or others. Their only alternative is to get in trouble with the law.

- Mental Health Association in Texas
Do Kids Count? (1989)

Primarily as a result of underfunding, the available services for troubled children and youth in Texas are targeted for the most seriously disturbed in the most restrictive settings. This means that children with SED must reach a point at which they are at risk of harm to themselves or others or get in trouble with the law before they can get help. At that point, residential care may be the only option. In Texas, residential services may be far from a young person's home, literally hundreds of miles for

those living in Lubbock and other West Texas communities.[24] Texas has six state hospitals and one community-based facility that provide inpatient care for children and adolescents. There are only 520 beds for all Texas youth needing residential care (96 beds for children and 424 beds for adolescents), and these usually can be obtained only on a short-term basis.

A study of 38 of the state's 45 mental health centers revealed that only eight centers have separate case management programs for children, six provide substance abuse therapy, and two offer child and adolescent day treatment programs.[25] These services are limited despite the fact that community-based services which focus on children and their families are considered more cost-effective than residential care, more helpful for the clients, and more satisfactory for families.

Increasing numbers of experts in the area are calling for a community-based mental health plan that is located in the public schools. Schools are where a large majority of children under age 18 spend many of their waking hours; they are where troubled children first tend to be recognized. They provide the most positive and accessible setting for implementing effective interventions.

Coordination of Services

Community-based services are being recognized as the optimum setting for persons of all ages with severe emotional disturbance. Beyond the setting, however, is the need for service coordination. Complex problems demand comprehensive solutions; they cannot be solved by programs that focus on a single problem or function. At a minimum, education, child welfare, and juvenile justice agencies must plan together for these young people. The U.S. Department of Education has pointed out that SED students require a range of services extending beyond special education to include counseling, therapy, social services, and in some instances residential care. As they have reported, "Unless services for this population are coordinated across agencies and with professionals, the effectiveness of each component is jeopardized."[26]

The need for coordination was recognized in Texas by the 1984 task force which recommended that TDMHMR create a position that would be responsible for coordinating mental health services for children. It also encouraged formal coordination at the state level with other agencies serving youth. In response to this recommendation, the department created the position of Coordinator of Children and Youth Services, in which the result has been greater awareness of the needs of the target population as well as making strides to coordinate agency services for youngsters with SED.

Turfism and tradition often interfere with the success of coordinated programs. It has been noted that "the obstacles to effective collaboration efforts are so imposing that they can serve as an insurmountable barrier for all but the most dedicated groups."[27] In the past few years, however, administrators and program directors have begun to recognize that they will lose neither funding nor status if they form part of a team. Legislative mandates and funding that require service coordination are providing strong incentives to the development of coordinated services. So, too, are mechanisms that bring together representatives of local education, health, and human service agencies to discuss issues and concerns about youth and share ways in which to serve those with severe emotional disturbance. Such coordination is especially important when federal and state dollars for public services are held steady or reduced.

The task force recommends that agencies that serve the target population conduct joint meetings at the community level in which to plan prevention and intervention strategies. The goal would be to discuss comprehensive approaches to serving children with SED and to determine the contribution that each agency would make to carry out the selected methods.

Collaboration and coordination should not be limited to the public sector. Organizations in the private sector can contract with the school system, for example, to provide therapy and other services on school campuses, reaching young people where they are and assuring that they can access the help they need. New programs are making a start in this direction. As they develop, they should be assessed carefully so that, if successful, they can be refined and expanded to school districts throughout the state.

Program Examples

Some examples of demonstration projects that the state of Texas should follow closely and support are efforts under way in Texas and in several other cities across the nation. Each of these projects is attempting to build comprehensive service systems for children and adolescents that focus on preventive and intervention strategies for emotional disturbance.

In all of these demonstrations, the community is viewed as the primary place for service provision while utilizing inpatient services only when it is absolutely necessary. All have potential for serving as models for other states. (For additional information on demonstration programs, see Appendix C: Resources.)

Without the midrange of services, children treated on an outpatient basis who fail to improve are often transferred to the other end of the continuum–that is, the hospital. The overuse or inappropriate use of hospitals in part relates to the use by these children who would not need to be hospitalized if appropriate services existed.

- Lenore Behar, Ph.D.
"Financing Mental Health Services for Children and Adolescents" (1990)

The Ft. Bragg Children's Demonstration Project, NC
Ft. Bragg was selected by the U.S. Army as the site in North Carolina for a model project attempting to serve many more children in military families with higher quality service at less cost than CHAMPUS (Civilian Health and Medical Program for Uniformed Services) was spending previously for inpatient treatment. The goal of the demonstration project is to develop a continuum of mental health services that will provide alternatives to unnecessary hospitalizations, prevent the need for hospitalization, and provide aftercare for those children who have been appropriately hospitalized. To evaluate the level of improvement for children in this project, two control sites will be used where these services are not available.

Ventura Children's Demonstration Project - Ventura, CA
The Ventura Children's Demonstration Project has five characteristics or planning steps: (1) multiproblem target population, (2) systems goals, (3) interagency coalitions, (4) services and standards, and (5) systems monitoring and evaluation. Initially implemented with funds from the California state legislature, the program has offset at least 66 percent of its cost by reducing other public agency costs and improving a number of client outcomes.[28] The project's successes in offsetting costs has provided a practical rationale for proposing increases in public mental health funds and has encouraged the legislature to provide additional funds for three other California counties.

Homebuilders - Tacoma, WA
The Homebuilders program is an intensive, in-home program designed to prevent the out-of-home placement of children. Its main goal is family preservation, which it carries out by intervening in crisis situations and providing services to seriously troubled families for a period of four to six weeks. When preservation services are successful, families learn to handle their own problems more effectively and avoid the emotional damage that can result from family separation.

Project Wraparound - Burlington, VT
This community-based demonstration project provides intensive, individualized, family- and school-based services to children who are severely emotionally disturbed. The programs' goals are to prevent any SED children in the project community from being placed in special classes, special schools, or residential programs and to serve all children with SED in mainstream, or integrated, environments.

Texas Dept. of MHMR Children's Demonstration Projects:
These projects were developed by the individual community centers and funded by TDMHMR out of the first-ever line item for children's community mental health services. In all, five projects were funded. Four of those projects are discussed below. (The fifth project was a joint effort between TDMHMR and the Texas Juvenile Probation Commission which will provide community-based mental health services to juvenile offenders with severe emotional disturbance in the Central Counties Community Center catchment area.)

Austin-Travis County Mental Health and Mental Retardation
This project designed by ATCMHMR will strive to decrease the reliance on institutional and residential care for emotionally disturbed children and adolescents. Its main goal is to maintain and preserve the family unit through an ecological approach which recognizes the interrelationship between child, family, and community. The concept is called the Family Preservation Project and is composed of three components: Home-Based Crisis Intervention, In-Home Family Support, and Respite Care. Each component focuses on the family as the unit rather than the child as a client. The project also emphasizes the importance of developing a community support system to help provide a continuum of care through a network of services.

Dallas County Mental Health and Mental Retardation
Dallas County MHMR will emphasize interagency coordination in its demonstration project. The agency plans to use multiagency case coordination by assigning three liaisons in key agencies. One liaison will work with the Dallas County Child Protective Services in the Family Preservation Unit, one with an assessment center at the Juvenile Department, and one with the supervisor of the new Day Treatment Program in the Dallas Independent School District school. The project will also fund CAST, a multiagency team that plans to conduct weekly meetings to discuss difficult cases of multiagency user youth.

Rio Grande State Center Community Services
Rio Grande State Center will organize advisory councils in each of the five counties in the service area to help make decisions regarding services and to develop interagency service planning. Family preservation will be the focus, with home-based mental health services provided by bilingual mental health professionals with expertise in child and adolescent behavior. The clinicians will work with families to

establish clear, obtainable goals with regular follow-up. Duration of treatment is expected to last four to six weeks, with some flexibility.

Sabine Valley Center

Sabine Valley Center will work closely with the Texas Network for Children and a newly created Case Resolution Council to identify needs and service availability for youth in this area. The services to be offered for children and adolescents are: In-Home Crisis Intervention, Case Management, Multidimensional Diagnostic Assessment, and Therapeutic Foster Homes with an emphasis on short-term, respite and crisis intervention.

Children's Mental Health System Analysis - Seattle, WA

The process of change and improvement in the children's mental health service system has been impeded by the absence of an empirically established data base to aid decision making. This model research and development project addresses that problem by creating a research base developed from information collected on children and adolescents with SED in the state of Washington. The analysis provides a comprehensive, empirical study of the target population's mental health and offers a model for other states that want more information about the mental health needs of children in their own states.

Texas Children's Mental Health Plan - TX

This is a new and integrated planning effort, facilitated by the Mental Health Association in Texas, in which eight state agencies plan together to serve troubled children. According to a July 1990 report, funds are to be allocated to each participating agency to carry out specified community-based core services, which are integrated in a comprehensive program for children and adolescents. For parents of children born at risk, program components include training in parenting skills and drug treatment for new mothers. For young school-aged children and their families, elementary-school-based health and human services will be provided for children identified as needing counseling and other types of help. For troubled older children, services will include family-focused community mental health care that is affordable and integrated with the schools, drug treatment for youth with serious emotional disturbance, and intensive treatment for adolescents in the juvenile justice system. Proposed allocations are $16,981,483 for fiscal year 1992 and $25,828,366 for fiscal year 1993.[29]

Robert Wood Johnson Foundation Demonstration Projects

The Robert Wood Johnson Foundation has established a national demonstration program to be funded in each of eight states. The program has been funded at $20.4 million for a four-year period. The goals of the project are the development of programs that serve children in the community and the creation of an incentive to restructuring the financing of children's services in these states.

The School of Tomorrow - Texas

The School of Tomorrow is a new school-based project designed to use neighborhood schools as the sites for providing an array of treatment and preventive services, including counseling and therapy, for children identified in need of help and their families. Program elements include integrating community services, keeping school facilities open before and after school, evenings, and weekends, identifying and reaching more children in need of social services, and making services more accessible for low-income families.

A planning phase was initiated in summer 1990 at four Texas sites: Dallas, Houston, San Antonio, and Austin. Local civic leaders, service providers, and school personnel at each site worked together to determine the services and methods of program implementation most suitable for their respective campuses. Initial five-year funding is provided by the Hogg Foundation for Mental Health.

We must reach beyond traditional notions of mental health as only in-office therapy and use our knowledge of mental health to create school-based support services that will help students with special needs meet realistic educational, behavioral, and life skills goals.

- Marian Wright Edelman
President, Children's Defense Fund
At the Schoolhouse Door (1990)

Family Support

For many years, mental health professionals and other service providers viewed parents and family members of youth with SED as barriers to the treatment and well-being of the children. A common if unspoken message was that if only the child could be separated from the parents, treatment could progress and all would be well. Today this view is obsolete. Current theory holds that children with emotional disturbance, along with children and youth with other problems, are best cared for by their families in their communities if this is at all possible.

Parent support programs that offer education and early intervention are proving effective in minimizing some of the risk factors experienced by many young Texans. For example, for first-time parents with at least one risk variable (such as being unmarried, a teenager, or living in poverty), regular home visits by a nurse during the mother's pregnancy and continuing through a child's first two years have been shown to reduce infant mistreatment significantly.[30] In turn, the potential for developing emotional disorders is diminished.

Parent education programs are receiving increasing attention nationwide. They should receive greater support in Texas, with effective programs replicated or adapted in communities throughout the state. Though they differ in method and intensity, these programs generally focus on the importance of early intervention, of parents as their children's first teachers, and of a comprehensive approach that offers support, early detection of potential problems, and knowledge of child development. Most offer a combination of home visits by trained parent educators and center-based visits where parents can meet other parents as well as obtain toys, information, and social services. The programs also include screening to detect developmental delays and health problems.

Among the most effective parent education programs in Texas are:
• CEDEN Family Resource Center's Parent-Child Program, a comprehensive bilingual (Spanish-English) program designed to serve high-risk, low-income families. Based in Austin, it is in use in three other Texas sites.
• Parents As Teachers, coordinated by the public school system with support from the Mental Health Association in Texas. The program has been adopted statewide in Missouri, where it was first tested. It is being pilot-tested in three school districts in Texas and has been adopted in several other Texas cities.
• AVANCE, a program for Hispanics which includes General Equivalency Diploma (GED) and English-As-A-Second Language classes as well as a project that involves fathers in family-strengthening activities. The program has four centers in San Antonio and one in Houston.

Another form of support is through advocacy groups, which are beginning to have increasing impact on policies and procedures for children and adolescents with SED. For the first time, parents are being treated as peer professionals. Through CASSP funding, three Families As Allies conferences have been held, resulting in regional planning and ongoing parent and professional collaboration; parents have attended national meetings of the Federation of Families of Children with Emotional Disturbance; and the Texas Alliance for the Mentally Ill (TEXAMI) is establishing AMI Child and Adolescent Network groups throughout the state. TEXAMI also has published a resource manual to help parents find services to help their children.

For us as advocates, policy makers and professionals interested in change, the challenge is twofold: to strengthen the mental health presence in the schools and to find ways to make sure that "non-identified" children can also benefit from that presence.

- Jane Knitzer, Ed.D.
"Children with Emotional and Behavioral Problems and the Public Schools: A National Perspective" (1990)

Both parent support and advocacy groups are helping meet the needs identified in a survey of parents of children with SED, in which involvement with other parents was cited as the most important source of help in coping.[31] These and other methods of family support should be studied and expanded.

Another form of family support that is gaining increasing attention is respite care. This service, which provides temporary rest and relief from caring for a child with SED, must be accessible, affordable, and flexible. At present, respite care for the most part lacks all of these characteristics. More effort should be made to design and finance respite programs that would serve the needs of local communities.

ORGANIZATION AND SUPPORT

Administrative Support

Although children and youth with severe emotional disturbance are gaining increasing notice, they are yet to be fully acknowledged at the administrative level in major state agencies. In 1987, TDMHMR created a position to coordinate children's mental health services. However, children are yet to have an advocate at higher administrative levels. The task force recommends that TDMHMR create a position of Deputy Commission for Children and Youth. This would indicate recognition of the importance of this population both within and outside of the agency as well as provide a stronger base for obtaining needed funds and services.

Resource and Referral

Families, primary care physicians, and other service providers often are frustrated in their attempts to find appropriate mental health services for children and adolescents. The problem is compounded if families have

limited financial resources.[32] Mental health services for this population are fragmented as well as limited, and obtaining information is difficult.

> *In the mental health arena, the myth that treatment must occur in a hospital or other residential setting also has created an over emphasis on out-of-home care.*
>
> - Beth Stroul, M.Ed.
> "Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed." (1988)

A resource and referral network would help remedy this problem. A start has been made by the Texas Networks for Children, Youth, and Families, Inc. (TNC), a statewide alliance of regional networks of service providers, referral sources, and funding and monitoring sources for troubled youth and their families. Currently, the program matches Texas children with SED with appropriate residential care, but its goal is to be able to match children with all appropriate services in a continuum of care. A private, nonprofit organization, TNC exemplifies how the public and private sectors can collaborate on behalf of persons with mental illness.

The use of computer-based networks should be explored as a means of maintaining up-to-date information about programs and services for youth with SED as well as serving as a source of information about the target population.

Training

The problem of how to attract qualified persons to practice medicine or provide other health services in rural areas is one that has vexed virtually every state in the country. No amount of financial incentive seems able to attract or keep well-qualified psychologists, social workers, or psychiatrists in the small towns and rural communities of East or West Texas or in the Valley. Seventy percent of the state's 213 child psychiatrists practice in four major urban areas.[33] Institutions that deliver specialized mental health services also tend to be concentrated in these areas. Resources that are available in rural areas tend to be separated by great distances, and public transportation generally is unavailable.[34]

Imagination and technology are needed to work out a better distribution of resources. Visiting consultants, a full repertoire of training materials, two-way videos, and weekly conferences via satellite are possibilities to

explore. A central quality-assurance program at TDMHMR is another possibility.

One way in which training could be improved is for academic programs to place greater emphasis on community-based services, the changed roles for parents of children with SED, and interagency collaboration. A stronger alliance between public agencies and academic institutions would encourage the development of more up-to-date, relevant training programs.

Program Evaluation

Throughout the field of human services, new programs suffer from a lack of evaluation. Without data on program effectiveness in serving a targeted population, there is no way to validate what aspects are worth continuing, how they should be refined or revised, whether the approach is cost effective, or even if the participants benefited from the effort. For this reason, many human service programs that were created in the 1960s and 1970s, good and bad alike, have fallen by the wayside.

The bottom line is that the [behaviorally or emotionally disturbed population], particularly from a programmatic point of view, has not been a focus of much research or evaluation....[W]e need better information about the nature and quality of school life for children with identifiable behavioral and emotional disorders.

- Jane Knitzer, Ed.D.
"Children with Emotional and Behavioral Problems and the Public Schools: A National Perspective" (1990)

This problem holds true for programs for children and adolescents with SED. Little information is available, for example, on the effectiveness of public school services or other community initiatives for these youngsters. Formative evaluation is necessary for providing ongoing information about the process and effectiveness of the many aspects involved in carrying out a program; high quality program evaluation is essential for an overall view of how a program has met its goals. For an objective perspective, evaluators from outside the agency or organization implementing the program can be valuable.

One new initiative, the Schools of Tomorrow that are being pilot tested in Dallas, San Antonio, Houston, and Austin under sponsorship of the Hogg Foundation, has a built-in evaluation component that should provide solid formative and summary data covering the programs' first five years. A committee of individuals from various disciplines that

have expertise in the area of evaluation will serve as advisors and consultants in the development of the design of the evaluation and the implementation of that design. This effort should be followed closely.

Funding Options

The cost of physical and mental health care is an increasing problem for all age groups, but it especially affects the young and minorities. More than half of all Texas children and youth under age 18 who live in poverty have no health insurance. Neither do 55 percent of Hispanics living in poverty and almost one-third of the total Hispanic population in Texas.[35] Only three of every ten Texas families have group insurance that covers hospitalization for youth with psychiatric disorders.[36]

Public and private health insurance must become more flexible and inclusive to enable children in need of mental health services to obtain the varied care that they require over a period of time.

Among the insured, funding for inpatient coverage exceeds that for other forms of care, but is still probably inadequate, at least for SED youth. Through Senate Bill 911, passed in September 1989, chemical dependency or addiction must be recognized and covered as a disease in insured risk-benefit group health plans. The most common coverage for this is 30-day rehabilitation where there is no copayment or deductible and treatment is on an inpatient basis. As a result, private insurance dollars are available for inpatient coverage but few are available for less restrictive levels of care.

The task force is convinced that the insured should have the flexibility to choose the type of care to be administered rather than be forced into a decision based solely on policy coverage. It appears that differences in mental health coverage in group insurance plans are attributable in large part to the designers of employee benefit plans and their representatives who convince employers of the benefits of their policies. It seems timely to work with insurance companies to develop more flexible coverage plans that would be more in line with current philosophy on community care and treatment.

Medicaid offers another option for funding mental health services. However, "few states have adequate eligibility criteria to ensure that individuals who may be expected to need significant mental health care are eligible for Medicaid."[37] According to the National Association of State Mental Health Program Directors, all states need to improve their Medicaid programs for community-based mental health services. Texas is high among the states not taking as full advantage of Medicaid options as it could. Far better use of Medicaid reimbursement could and should be made within the existing system.

A small number of children use most of the available resources, mainly extensive inpatient and residential treatment center (RTC) care, which is costly. Seventy percent of the child mental health dollar goes toward these institutional services and the care is not necessarily effective.

- Barbara J. Burns, Ph.D.
"Critical Research Directions for Child Mental Health Services" (1990)

Research

Research in children's mental health has not received the attention it warrants. There is no clear understanding, for example, of the relationships between risk factors and mental disorders or of how multiple risk factors compound the problem or complicate treatment.[38] According to the National Advisory Mental Health Council (NAMHC), "Scientific effort and progress in understanding and treating the mental disorders of children and adolescents have not kept pace with the scope of the problem, the urgent need for answers and action, and the scientific field's readiness to move forward."[39]

In April 1990, the NAMHC submitted to Congress a three-point plan to address the lack of researchers, resources, and equipment needed to improve the diagnosis, treatment, and prevention of child and adolescent mental disorders. Based on a 1989 report of the Institute of Medicine, this plan includes recommendations for research, training, and funding. The report is being studied by Congress.

Mental health professionals differ on the types of research that should be given priority. At the February 1990 conference of the Research and Training Center for Children's Mental Health of the Florida Mental Health Institute, various options were discussed. Some participants favored the random assignment of children to treatment so that different systems could be compared, while others thought it too early for comparisons and favored more fundamental research. The need for studies on minority children was emphasized, as was the need for incentives for minority researchers to work in the public sector.[40]

The National Institute of Mental Health funds five centers that deal with organizing and financing the care of the severely mentally ill, but their focus until recently was on adults. Only now are they beginning to address issues relating to children and adolescents. Furthermore, none of these centers is located in the Southwest. The addition of a research center in Texas would be of value in improving services for children and adolescents with SED in Texas and its adjoining states.

THE NEXT STEPS

When the task force first met, members were not surprised to find that resources and service delivery systems in Texas were inadequate to meet the needs of children and youth with severe emotional disturbance and the families of these young people. They were appalled and frustrated, however, at the dearth of information about this population. How could they devise more effective services, for example, for a population that has no common definition among agencies that serve it? How could they determine specific needs when no statewide data base exists for children and youth with SED? How could they determine the most effective types of programs when research is limited and programmatic efforts are fragmented, lack evaluation, or are still in their initial stages?

With this realistic view of the field, the task force took a basic approach to its study, focusing on the initial steps needed in order for progress to take place. As outlined in this report, the population must be defined and enumerated before it can be served more effectively. Ongoing programs must be watched closely and evaluated to determine their potential for refinement and replication. Children and youth with SED must be identified so that they can be served. The task force cautions, however, that if these youngsters are labeled, they must be provided with services to help them and their families.

Virtually no mention has been made of the need for funds to provide more and better services. This need is widely recognized; little purpose would be served by dwelling upon specific funding needs here. Policymakers and planners must understand that, in the TDMHMR budget, funding requests should better reflect the needs of children and youth. The legislature should heed these requests if services for SED youngsters in Texas are to begin to catch up with services available in other states.

This report lays the groundwork for future action in Texas to help a young population in need. The next steps are up to the stakeholders. Stakeholders, in this instance, have been defined as persons who work with or for children and youth with severe emotional disturbance. This includes professionals in mental health, medicine, education, and social services. It includes parents, volunteers, and advocates. When one thinks about it, stakeholders include all Texas citizens who care about today's children and adolescents, tomorrow's adults. The next steps are up to us.

Even with the programs which existed in 1978–many of them the legacy of the Great Society, a period of expansion in special programs which many have interpreted as a great boon to children and youth–the deficiencies of existing spending patterns are serious, and they are likely to become more serious still over the next few years. It is hard to see in these spending patterns the signs of a child-centered society....Although we may have made some progress since the 1930s, our social spending policies for children and youth still have far to go.

- W. Norton Grubb and Patricia Heilburn with Christine Galavotti
Far, Far to Go: Public Spending for Children and Youth in Texas (1982)

APPENDIX A

LIST OF "KEY STAKEHOLDERS" MEETING PARTICIPANTS

Representatives of state agencies and organizations that work with SED youth were invited to attend the meeting of the Task Force on Children and Adolescents with Severe Emotional Disturbance on August 1, 1989. The following "key stakeholders" and Task Force members attended:

David Bean, M.D.	Texas Department of MHMR
Judy Culpepper Briscoe	Texas Juvenile Probation Commission
Frank Dietz	Texas Conference of Churches
Kathleen Hamilton	Texas Department of Human Services
Regenia Hicks, Ph.D.	Texas Department of MHMR
Deborah Hiser, J.D.	Advocacy, Inc.
Kimberly Hoagwood, Ph.D.	Texas Education Agency
Michael Kane	Pelavin Associates, Inc.
Pamela Johnston	Texas Alliance for the Mentally Ill
Jay Lindgren	Texas Youth Commission
Spencer McClure	Texas Council of Community MHMR Centers
Stella Mullins	Mental Health Association in Texas
Tom Olsen	Health and Human Services Coordinating Council
Muriel Folloder Phillips	Houston Advocates for Mentally Ill
Ken Vogel	Texas Rehabilitation Commission
David Winship	Texas Network for Children

Task Force members present:

Robert McKelvey, M.D., Chair
Carl Pfeifer, M.D.
Aracelli Casso, M.D.
Frank Rafferty, M.D.
Regenia Hicks, Ph.D.
Beverly Sutton, M.D.
Ira Iscoe, Ph.D.
David Warner, Ph.D.
Leonard Lawrence, M.D.
Glenda Kroll, M.D.

APPENDIX B

TARGET POPULATION DEFINITION FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE*

Must have (I, II, & III) *or* (I, II, & IV) *or* V:

I. DIAGNOSIS

DSM-III R Axis I or II diagnosis,** except a single diagnosis of psychoactive substance use disorder, developmental disorder, or V code. Organic mental disorders are included only while behaviors are a danger to self or others.

II. RISK OF OR SEPARATION FROM FAMILY

Risk of or separation from family due to, for example: (1) chronic family dysfunction involving a mentally ill and/or inadequate caretaker, or multiple agency contacts, or changes in custodial adult or (2) going to, residing in, returning from any out-of-home placement, e.g., psychiatric hospital, short-term inpatient, residential treatment, group or foster home, corrections facility, etc.

III. FUNCTIONAL IMPAIRMENTS/SYMPTOMS

Must have A or B:

A. Functional Impairment. Must have substantial impairment in two of the following capacities to function (corresponding to expected *developmental level*):

1. Autonomous functioning.
2. Functioning in the community.
3. Functioning in the family or family equivalent.
4. Functioning in school/work.

B. Symptoms. Must have one of the following:

1. Psychotic symptoms.
2. Suicidal risk.
3. Violence: At risk of causing injury to person or significant damage to property, due to mental illness.

IV. HISTORY

Without treatment, there is imminent risk of decompensation or separation from family in Section II above.

V. SPECIAL EDUCATION STUDENTS

Special education students who have been assessed as being seriously emotionally disturbed and have identified mental health needs in their individualized education plans.

* A product of the Interagency Children's Mental Health Initiative, facilitated by the Mental Health Association in Texas, 1990.

** Axis I - Clinical Syndromes; Axis II - Developmental Disorders and Personality Disorders.

APPENDIX C

The following documents, publications, conferences and programs were used in the development and/or discussed in this report. They contain further information on the current status and needs of children and adolescents with emotional disturbances.

Publications

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Warner, D. (Ed.). (1977). *Toward Human Rights: The Social Policies of the Kennedy and Johnson Administrations*. Austin, TX: Lyndon B. Johnson School of Public Affairs.

Conferences

A System of Care for Children's Mental Health: Building a Research Base. Third Annual Research Conference. February 12-14, 1990. Tampa, FL.

Youth in Texas: Financing and Coordinating Services for the Severely Emotionally Disturbed. April 5-6, 1990. Austin, TX.

Projects

The Ft. Bragg Children's Demonstration Project
Department of Human Resources
Division of MHMR, Child and Family Services
Raleigh, NC
Phone: (919) 733-0598

The Ventura Children's Demonstration Project
Division of Mental Health Services
300 Hillmont Ave.
Ventura, CA 93003
Phone: (805) 652-6737

Homebuilders Project
Behavioral Sciences Institute
34004 9th Ave. S., Suite 8
Federal Way, WA 98003-6796
Phone: (206) 927-1550 or 874-3630

Project Wraparound
Psychology Department
University of Vermont
Burlington, VT 05401
Phone: (802) 656-1140

TDMHMR Children's Demonstration Projects:

Austin/Travis County Mental Health and Mental Retardation Center
Family Preservation Program
3001 S. Lamar, Suite 203
Austin, TX 78704
Phone: (512) 440-7277

Dallas County Mental Health and Mental Retardation Center
Alliance for Family Interagency Rebuilding
1341 W. Mockingbird Lane, Suite 1000-E
Dallas, TX 75247
Phone: (214) 637-4600

Rio Grande State Center Community Services
P.O. Box 2668
Harlingen, TX 78551-2668
Phone: (512) 423-5077

Sabine Valley Center
P.O. Box 6800
Longview, TX 75608
Phone: (214) 758-2471

Children's Mental Health System Analysis
Department of Psychiatry and Behavioral Sciences
Division of Community Psychiatry
University of Washington
RP-10, BB1616
Seattle, WA 98195
Phone: (206) 543-7530

Robert Wood Johnson Mental Health Services Programs for Youth
56 Livingston Ave.
Roseland, NJ 07068
Phone: (201) 716-8000

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